Aporia vol. 24 no. 1—2014

A Philosophical Investigation of Principlism and the Implications Raised by the Treatment of the Mentally Ill

Benjamin Foster

Introduction

The objective of this investigation is to identify reasonable and relevant problems and issues posed for Principlism by the mentally ill. Two concepts of Principlism will be presented: a normative conceptualization of the bioethical theory and a descriptive conceptualization. In reference to both, two philosophical questions will be asked: can we know the natures of other minds and, if so, how? These two questions have theoretical and practical implications for the treatment of the mentally ill. And, in so far as the questions have implications for the treatment of the mentally ill, they have implications for the bioethical theory of Principlism.

There is a lack of concurrence on the meaning, nature, and function of mental phenomena, producing conceptual difficulties concerning the common morality that provides Principlism its normative authority. Similarly, a contradiction appears to arise when one considers the imaginative leap of predicting another's desires, feelings, and thoughts, a maneuver that professionals participating in the treatment of the mentally ill must perform. There is also significant ambiguity surrounding the concept of mental illness, which produces pragmatic problems when professionals attempt to diagnose and treat an individual in conjunction

Benjamin Foster graduated with a degree in philosophy and a minor in biology from the University of Alaska Fairbanks. While there he served as president of the university's philosophy club, The Socratic Society. His primary philosophical interests include ethics and epistemology. He currently plans to attend medical school.

with a unified ontological theory of mental phenomena. Further, there are pragmatic complications when the contemporary surrogate decision making standards are specifically applied to the mentally ill.

Principlism

An initial discussion of Principlism is important for the purposes of this investigation for two reasons. First, there is apparent disagreement concerning the nature of Principlism. Second, bioethical theories, such as Principlism, are more or less vulnerable to various objections depending on how they are characterized or defined. Therefore, in order to identify *relevant* objections, Principlism will be defined and discussed in more than one way, thereby providing a fuller understanding of a major element within the investigation.

Principlism might be best understood by looking at how it was developed. Early on, bioethicists noticed that despite their disagreement on which moral theory was correct, they nevertheless agreed on how to resolve particular cases and larger issues because they shared a commitment to several core ethical principles. This early realization was probably made most clear in 1979 when two seminal pieces were initially published: *The Belmont Report* and *Principles of Biomedical Ethics*.

Produced by the first National Commission for bioethics, *The Belmont Report* proposed the principles of *respect for persons*, *beneficence*, and *justice* as the ethical principles that should govern research with human subjects. The second publication, *Principles of Biomedical Ethics*, articulated four rather than three principles by distinguishing beneficence from *non-maleficence.* These straightforward principles appealed to bioethicists, philosophers, lawyers, doctors, nurses, and even patients. As such, bioethicists appeared to have found a language or method of analysis that accomplished, to a degree, the discipline's pragmatic aims as well as enabled an understanding and participation of other parties relevant to and involved in the bioethical discussion. The core ethical principles that were observed to hold became *principles*, and their use in the method of analysis of ethical issues is now commonly called "Principlism."

Each of the principles can be briefly defined as follows:

> *Respect for Autonomy/Persons:* (i) a *negative* obligation to recognize a person's right to choose and avoid patient coercion; (ii) a *positive* obligation to provide the information necessary for autonomous choice (i.e. diagnosis, prognosis, and treatment options) and to ensure adequate understanding of the knowledge.

> *Non-maleficence*: an obligation against harming or imposing risks of harm on others. Harm is generally understood as both *bodily injury* and *set backs to significant interests*.
>
> *Beneficence*: an obligation to provide benefits to other people.
>
> *Justice*: often considered a "super principle" including several related principles. This principle proscribes the basic obligation to insure the fair and equitable distribution of benefits and burdens, in accordance to such things as need, effort, or merit.

Here are the two ways in which Principlism can be characterized and should be distinguished: 1. Principlism, in a more normative sense, as an action-guiding criterion for *right action*; and 2. Principlism, in a more descriptive sense, as a guide for discussing and *justifying* moral beliefs and actions.

Principlism in a More Normative Sense Concerned with Rightness

When discussing *principles of right action* and *criteria of right action,* one considers statements of necessary and sufficient conditions for the rightness of action. Therefore, principles identify the property that is shared by all morally right actions, a property by virtue of which a morally right action is *morally right*. For example, the principle of respect for autonomy is profoundly influenced by the *deontological* moral theory of Immanuel Kant. This is to say it is rooted in a criteria in which the property shared by morally right actions is the property of *being such that the agent of the action can consistently will that the action's maxim be universal law, i.e., that you treat humanity, whether in your own person or in the person of any other, never merely as a means to an end, but always at the same time as an end.* The principle of justice is equally influenced by the *utilitarian* moral theory. However, according to utilitarians, the property shared by morally right actions is the property of *being an action that maximizes utility, i.e., happiness, for all rational beings.*

Constructed with at least two divergent maxims for right action, and lacking a particular overarching value, spurs the criticism that there is no way to solve the inevitable conflicts between principles. Such conflicts between the principles of *respect for autonomy* and *justice* are indeed prevalent, especially when determining the moral treatment of mentally ill patients (i.e., involuntary commitment). In response Beauchamp and

Childress created an action guiding criteria of their own. Beginning with the third edition of *Principles of Biomedical Ethics*, the authors changed the source of their mid-level bioethical principles from "high philosophical theory" to "the common morality" (Arras). They claim that the *common morality* is common to all persons in all times and places who are committed to living a moral life. Thus, the authority of the common morality is established historically and pragmatically through the success of the common norms in all times and places, advancing the cause of human flourishing.

Principlism in a More Descriptive Sense Concerned with Justification

When speaking of justification, one is discussing the process by which one aligns their moral *beliefs* within a particular circumstance, and then aligns these beliefs with their actions. A method of justification is found in *Principles of Biomedical Ethics* (Beauchamp and Childress 2013). The chapter "Method and Moral Justification" describes the method of *reflective equilibrium*, which is widely accepted as a method by which one's particular moral beliefs and general moral principles become justified (381–87). The method of reflective equilibrium encourages the moral agents to start with their considered moral judgments, and then test their moral beliefs and principles against these judgments. This reflexive process requires that one continue to adjust one's beliefs and principles until one creates a perfectly coherent set, where some of the beliefs and principles that make up this set provide support and serve as explanations for others. The reasoning moves from the specific, which helps to inform the general, and then applies to another specific. The more cohesive the beliefs and principles become, the more justified those beliefs and principles become. Once these beliefs attain a certain degree of justification, acts that coincide with them gain moral justification as well.

Theologians, anthropologists, historians, and philosophers alike have observed a number of specific and commonly recognized moral principles. Viewing the four principles as demonstrative propositions does not raise any immediate objections. In this sense, they form a framework for ethical analysis and deliberation, or dialog. When utilized with the process of relfective equilibrium, such dialogs are able to compare, develop, and strengthen the justifications for various moral beliefs and ultimately produce justified ethical actions.

The Philosophical Issues

To reiterate, this investigation is not aimed at defending either one of these definitions. The aim instead is to produce two reasonable concepts of Principlism that can be used in light of the philosophical issues presented next. Once the philosophical issues are understood, then the reader can see how these are relevant to either alternative conceptualization, and thereby arrive at a fuller understanding of the possible implications they pose to the theory of Principlism overall.

The Nature of Mind and the Mental

What *is* the mind? For some, this question translates as "What am I?" and for others as "What is this illusion?" This fundamental philosophical question has occupied Western thought since the pre-Socratics. Anaxagoras postulated that *nous,* mind, was the principle cause of the Kosmos, and could be found inhabiting and directing all things (Wheelwright 160). Today, philosophers, neurobiologists, psychologists, and many others investigate the nature and identity of the mind. Arguably, significant advancements have occurred within multiple methods of inquiry concerning "the mind" and have produced a variety of arguments regarding its character, origin, and function. An answer to the identity of the mind is not required for this investigation. However, the apparent *disagreements* on the subject are important to consider because *mind* has become an *object* within much of medical theory and practice. The nature and implications of this objectification are clearest when the theories of Western medicine, *pathology*, are examined.

The publication of *Cellular Pathology as Based upon Physiological and Pathological Histology* in 1858 by Rodolf Virchow is considered by many to be the birth of modern scientific medicine. In it Virchow claims that the basis of all disease is injury to the smallest living unit of the body, the cell (Rubin and Farber 2). The co-authors of *Essential Pathology*, Emanuel Robin and John L. Farber, observe that both clinical and experimental pathology remain rooted in Virchow's cellular pathology. Take for example the definition of disease posited by *Robbin's Basic Pathology*, the standard American pathology text. In it *disease* is defined by what a pathologist *does:*

> Pathologists use a variety of molecular, microbiologic, and immunologic techniques to understand the biomechanical, structural and functional changes that occur in cells, tissues and organs. To render diagnosis and guide therapy, pathologists identify changes in gross

> and microscopic morphology of cells and tissues, and biochemical alterations in body fluids. (Kumar et al. 1)

Thus, according to pathological-scientific criteria, disease is a *material* phenomenon, the product of the body, in the same sense that urine and mucus are products of the body. Diseases of the body have causes such as infectious agents or nutritional deficiencies and can, therefore, often be prevented or cured by dealing with the causes. When the mind is objectified in this theoretical vein, mental health problems stand in the same relation to brain disease as urinary problems stand in relation to kidney disease. Mental problems become symptoms of brain disease, and thus the doctor may *diagnose* as well as *treat* mental illness as if it were brain disease.

Despite historic and contemporary disagreement regarding the identity of the mind, modern Western medicine has assumed the material-biological definition by equating it to the anatomy and physiology of the brain. As an objective and scientific concept, medicine regards the *person*, the potential sufferer, as unimportant. In this sense, the reduction of mental phenomena to brain function is especially useful for investigators by removing from the deliberation the subjective phenomena that cannot be quantified. In contrast, the practice of medicine as a *human service* regards the person as a subjective patient with emotions, thoughts, beliefs, feelings, and opinions. This human oriented aspect of medicine cannot be dismissed, for Western medicine is informed by the ethical dictation, "*Primum non nocere!*"

As a theory concerned with ethics of medical care, Principlism is required to consider the conceptual use of ideas such as illness and treatment, as well as how they pertain to mental phenomena. It would appear, therefore, that the before mentioned observations are in some important ways relevant to the theory of Principlism.

The Problem of Other Minds and the Nature of Imaginative Leaps

The problem of other minds is a philosophical problem that is best described as tamed rather than solved. Since its formal introduction into the Western philosophical conversation by John Stuart Mill, various solutions have been created; however, none of these solutions could plausibly lay claim to enjoying consensus. Stated simply, the problem of other minds is the problem of how to justify the belief that other individuals have minds that are very much like one's own. That is to say, others have emotions, thoughts, beliefs, feelings, opinions, and experience the world in very similar fashions as one experiences one's self. We do not believe that we always or even mostly know the others' *inner lives* in extreme detail, but we

do not doubt that similar inner lives exist. But how do we justify this basic and fundamental human belief?

The assumption that a patient has a similar and *common* mind is an especially useful belief for a medical practitioner. Such a belief is in many ways *essential* to the ethical reasoning expected of a medical practitioner. Without the assumption of similar minds, it would be impossible to feel the emotions tied to moral judgments. For solidarity to be established between a doctor and patient, the doctor must imagine what it would be as if he or she were tied to a dialysis machine, to suffer the loss of a family member, to hallucinate, or to lose his or her perceptual senses. If empathy and a physician's subjective perceptions are denied relevance in ethical reasoning, in hopes of utilizing a more objective method, a doctor must still perform an imaginative leap built on the assumption that a particular patient's mind is common to the similar mind most often observed.

Whether or not this intuitive assumption is justified is not the concern of this investigation. What should be noted is that the belief in others having a similar mind is held by practically all people and is often taken for granted and assumed legitimate in many of our moral theories. More importantly, medicine requires a practitioner to form this sort of psychological identification with the patient. It requires an imaginative leap built on the assumption of similar other minds. However, since one of the necessary conditions for mental illness is mental dissimilarity, a conceptual issue appears to arise for any moral theory relying on the assumption of other minds and the exercise of imaginative leaps. At the very least, it appears that ethical deliberations regarding the mentally ill cannot employ these assumptions axiomatically.

Implications Posed by the Identity of the Mind

With attention towards the conceptual foundation of Principlism's authority, the ambiguity surrounding the nature of the mind poses significant implications. Recall that its four primary principles are derived from the "common morality," which is defined by the authors as the morality common to *all persons in all times and places* who are committed to living a moral life. Unlike other historicist accounts, Tom Beauchamp and James Childress maintain that the four proposed norms of common morality are universally binding. If their historicist method is granted the ability to discover universal normative propositions, it still seems appropriate to examine the effectiveness with which the method was applied. Consider just briefly how drastically different the understanding of mental phenomena and treatment of individuals currently considered

mentally ill have been throughout human history. They have been viewed with fear and assumed to be possessed by evil spirits—a view that often resulted in either their drowning or burning. Or, they have been viewed with disgust, assumed to be biological waste, resulting in their mass murder within the concentration camps of Europe. Conversely, in other times and places, they have been viewed with respect and reverence, thought to posses a spiritual gift, resulting in their appointment as shamans. Even recently Western medicine's treatment of such individuals has shifted from a heavily paternalistic approach to attitudes and methods more concerned with patient autonomy. These observations of dissimilarity demonstrate that while forming their normative definitions, Beauchamp and Childress did not include the mentally ill patient population.

This would suggest that Principlism, in the normative sense, must either deny the mentally ill patient *personhood* or relinquish its action guiding principles' universal and necessary character. However, in the demonstrative sense, the principles are free to change throughout time as they become justifiably more or less coherent via observation and the process of reflective equilibrium. As such, the inaccuracy of the principles' formulation method only implies that the theory's tenets require revision via future application of the process of reflective equilibrium.

In addition to the before mentioned conceptual implications previously just discussed, the way in which the mind is defined raises practical considerations for Principlism. To view and define mental phenomena in terms of, and fundamentally *as,* various brain functions is a perspective gaining support from philosophers, contemporarily most influenced by the works of Patricia and Paul Churchland. They argue that through a process of eliminative materialism and complete neuroscience the "folk psychological" concepts of the mind will be replaced entirely by neurological definitions and understanding (Churchland 84). As such, all human behaviors and their causes can be attributed to and described as neurological functioning.

A unified perspective of human behavior, whether it is rooted in genes, neurons, or childhood experiences, is cautioned against by endocrinologist and primatologist Robert Saplosky, who argues that human behavior is much more complex. For example, sometimes the non-mental processes occurring in the body can dramatically influence what's occurring in the brain. An obvious example would be the foods the body digests. Conversely, sometimes what's going on in the brain will affect every single outpost in the body. An example would be experiencing an increased heart rate, increased perspiration, and increased respiration when attempting to sleep while at the same time contemplating one's mortality.

Sapolsky also points out that when studying behavior one first asks, "What does the behavior look like?" One then proceeds to investigate what went on in that organism's brain a half-second before that behavior occurred. However, one could then ask, "What smell, sound, or other sensory stimulation in the environment caused those neurons to get activated and produce that behavior?" This is followed by another reasonable question, "What were the hormone levels like in the blood in the last few hours that changed how sensitive one was to those sense stimuli?" These questions can be followed by investigations into an individual's early development, fetal life, their genetic makeup, and the genetic makeup of the parents (Sapolsky). To say that behavior, the stuff of mental illness, is simply the result of the activity of the brain does not appear necessarily valid.

Sapolsky's insights and cautionary words demonstrate that thinking of human behavior as *merely* neurological functioning poses real limitations on a doctor's investigative and diagnostic abilities. Patricia Churchland, as well as any other honest neurobiologist, will admit that a complete understanding of the brain is far from completion. Questions relating to how information is coded in neurons, the organization of motor responses, how memory is orchestrated across a network, time management, sleeping, and dreaming, and how information is retrieved, remain unanswered. However, these unknown aspects of neurology are particularly relevant in certain mental illness, such as the loose associative thinking of schizophrenics and the disturbances or loss of memories characterizing amnesia. To think about and treat the mind solely in terms of the brain appears to significantly limit *current* abilities to understand, work with and treat mental phenomena.

As a pragmatic theory concerned with bioethical issues such as treatment, these observations regarding the conceptualization of the mind and what they can contribute to the treatment of the mentally ill are extremely important.

Implications Posed by Imaginative Leaps

The imaginative leap that underlies the problem of other minds and used in the assumption of similar minds appears to warrant special consideration when the aim of the leap is towards a mind that is by definition dissimilar. The imagination has its limitations. It is obvious that it is much easier for someone to imagine what it would be like to undergo a particular experience them self than it is to imagine what undergoing that experience is like for *another* person. A second kind of imaginary leap requires one to imagine what it would be like to share

another individual's particular, subjective point of view, what it is like to *be* another person. To imagine what it would be like to be another person requires one to imagine the logically impossible: what would I be like if I were no longer me? It may very well be impossible, but practically this does not matter if we assume the existence of other similar minds when in fact there appears to be a similar mind present. Due to similar minds, one person's experience is typically close enough to those of another so as to produce a pretty close approximation. However, when a dissimilar mind is added to the equation, one can expect difficulty.

Bioethicists have observed difficulties with approximating other minds when treating children and individuals who are either temporarily or permanently in a coma. In response, Principlism invented a number of surrogate decision-making standards considered to be ethical substitutes for a patient's current wishes, or lack thereof. Their most common formulations can be summarized as follows:

> A. *Prior expressed wishes.* Doctors will often encourage healthy mentally sound patients to consider and articulate the treatment they would like to receive (or not receive) if they were to become incapacitated, either mentally or physically, in the future. If the patient happens to reach such a state, the doctor will then employ treatment based on those patient's wishes. This is often the surrogate standard used when treating a mentally ill patient who was once in possession of normal mental abilities, such as the demented elderly or patients with Alzheimer's disease.
>
> B. *Substituted judgment.* Oftentimes people do not express in advance their preferences and aversions as to treatment in the event they develop a mentally impaired state, or in more unfortunate cases, the mentally ill patient has never been mentally sound. In such cases, and similar cases created by other illness, the physician often employs the substituted judgment standard that asks, "What would this patient choose if they were able?"
>
> C. *Best interests*. Medical decisions for the severely mentally ill are sometimes made utilizing a third standard, the best interest standard. Following this standard, practitioners should act in a way that tey judge to maximize benefit to the patient. This judgment is determined by calculating the highest net benefit produced by available actions, assigning different weights to interests the patient has in each, and subtracting inherent risks and costs.

While largely unproblematic in respect to dealing with other patient populations, Carl and Britt Elliot have demonstrated that the severely or permanently mentally ill can be a particularly troublesome class of patients because each standard requires, to some degree, an imaginative leap into an especially dissimilar mind (173 – 78). The Elliots point out that among the three previously mentioned decision making standards, the best interests standard enjoys the advantage of not having to attempt to imagine the logical contradictions which may be entailed by a) a patient imagining oneself as mentally impaired (prior expressed wishes), or b) practitioners imagining the mentally impaired individual to be mentally sound (substituted judgment) (174 – 76). However, Allison B. Seckler et al. demonstrated that although most patients predicted that both their physicians and family members would accurately represent their wishes, neither physicians nor family members were adequately able to do so (96 – 7). As such, despite its conceptual advantage, the best interest standard appears to remain ineffective when actually applied.

Despite the attempts made with these standards to apply ethical reasoning involving abnormal patients, their particular application to the mentally ill still appear to be conceptually and practically cumbersome. When the first observation, the existence of a significant conceptual contradiction, correlates with the second observation of persistent practical limitation, the mentally ill appear to pose a particularly strong objection to implementation of Principlism. Whether or not this current difficulty constitutes a fundamental theoretical pitfall depends on how the caveats, sub-principles, are treated within the reflective equilibrium method and the confidence one puts in the method to produce more justified beliefs.

If the standards for substituted judgment and other such sub-principles are considered justified beliefs rather than normative dictums, then there is not *necessarily* an immediate problem. If treated as such, contemporary standards like substituted judgment are reduced to temporary propositions. Determined by their coherence to one another and with the fundamental four principles, a belief's reduction, elimination, or addition is always possible. It is quite possible that a more coherent set of beliefs and principles will be formed via the introduction, development, and justification of new beliefs (i.e., a more ethical and effective means of communication and understanding). There is also the possibility that coherence is improved via the reduction or elimination of current concepts and beliefs (i.e., ethical treatment and mental illness). Therefore, although the mentally ill currently implies a conceptual impasse to ethical reasoning that relies significantly on imaginative leaps, there appears to be no reason to conclude that Principlism's pragmatic aims are compromised by it. If the assumptions and sub-standards are

considered in this way, as being *currently* prevalent and somewhat justified beliefs, then the theory's questionable ability to be implemented towards the mentally ill only necessarily informs the healthcare professional to proceed with extreme caution and to continue developing his or her ethical principle-belief set.

Conclusion

The confusion surrounding the concept of mental illness is not merely the product of philosophers' attraction to argumentation; rather the confusion appears to be an on going problem for those who contemplate mental phenomenon. More importantly, the implications of how mental illness and related terms are defined are not confined to the conclusion of a philosopher's thought experiment. How these terms are defined, and who defines them, has immediate and tangible effects; i.e., making pharmacology the country's most profitable industry, acquitting an individual of murder, availability of government funds and assisted living, as well as the type and efficiency of available treatment and care. Due to its significant presence in the rhetoric of the medical culture as well as the vernacular of the larger Western culture, it is important to investigate where the concept reasonably leads.

When applied in this investigation, the term "mental illness" demonstrates that a number of relevant conceptual and practical implications face the medical practitioner and thus pose relevant implications towards the theory of Principlism. The various definitions and attitudes towards the *mind* and *mental illness* observed both past and present call into question the accuracy of important definitions utilized by Principlism, and consequently the theory's normative claim. The material objectification of mental phenomena by Western medicine has a practical advantage for medical *study*, but does not suit the *human service* aspect of medical practice. Furthermore, while this conceptualization of the mind as brain is currently gaining popularity, it still requires extensive support to be considered valid. More importantly, such a conceptualization does not warrant sole consideration in diagnosis and ethical treatment as the principle cause for behaviors related to mental illnesses and mental phenomenon. The mentally ill's defining characteristic of being mentally *dissimilar* requires caution to be utilized when making assumptions relating to the nature of the minds of others (i.e., desires, emotions, and values). As assumptions utilized in a fundamental way by health care professionals, the precaution required by mental illness implies that Principlism

in both of its conceptualizations should make acknowledgment of this severe difficulty and attempt a theoretical examination and restructuring.

These are my observations, and reasonable illustrations of them for the consideration of the reader and the bioethical discussion are my aim. Without the ability to provide definite answers, I hope the investigation serves to help individuals considered mentally ill by increasing future empirical investigations by degrees of keenness and rational reflections by degrees of fullness.

Works Cited

Arras, John. "A Taxonomy of Theoretical Work in Bioethics." Stanford Encyclopedia of Philosophy. Stanford University, 2010.

Beauchamp, Tom L. and James F. Childress. *Principles of Biomedical Ethics*. 3rd ed. New York: Oxford UP. 1989.

——. *Principles of Biomedical Ethics*. 6th ed. New York: Oxford UP. 2009.

——. *Principles of Biomedical Ethics*. 7th ed. New York: Oxford UP. 2013.

Churchland, Paul M. "Eliminative Materialism and the Propositional Attitudes" *Journal of Philosophy*. 78.2. (1981): 67–90.

Elliott, Carl, and Britt Elliott. "From the Patient's Point of View: Medical Ethics and the Moral Imagination." *Journal of Medical Ethics.* 17.4 (1991): 173–78.

Kumar, Vinay, et al. *Robbins Basic Pathology*. 8th ed. Philadelphia: Saunders Elsevier, 2007.

Noel, Hans. *Creative Synthesis: A Model of Reflective Equilibrium and Ideology Formation.* Diss. U of Michigan, 2010. Ann Arbor: UMI, 2010.

Rubin, Emanuel and John L. Farber, *Pathology.* Philadelphia: Lippincott, 1994.

Sapolsky, Robert. "Introduction to Human Behavioral Biology." Stanford U, Palo Alto, CA. 29 Mar. 2010. Lecture.

Seckler, Allison B., et al. "Substituted Judgment: How Accurate Are Proxy Predictions?" *Annals of Emergency Medicine.* 115.2 (1991): 92–98.

Virchow, Rudolf. *Cellular Pathology as Based upon Physiological and Pathological Histology.* London: Churchill, 1860.

Wheelwright, Philip. "Anaxagoras," *The Presocratics.* New York: Macmillan, 1986. 160.